A REPORT
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ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit

Arizona Health Care Cost Containment System

Sunset Factors

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Auditor General

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September 24, 2002

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Ms. Phyllis Biedess, Director
Arizona Health Care Cost Containment System

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Arizona Health Care Cost Containment System (AHCCCS)—Sunset Factors. The analysis of the 12 sunset factors was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee and prepared as a part of the Sunset review set forth in Arizona Revised Statutes (A.R.S.) §41-2951 et seq.

This is the fifth in a series of five reports to be issued on the Arizona Health Care Cost Containment System.

The report includes a written response from AHCCCS.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on September 25, 2002.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has prepared an evaluation of the Arizona Health Care Cost Containment System (AHCCCS) using the 12 criteria in Arizona's sunset law. The analysis of the 12 sunset factors was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee and prepared as a part of the Sunset review set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 et seq.

The Sunset review of AHCCCS also included a series of four performance audits. The audited areas covered the Division of Member Services, processes AHCCCS uses to set its capitation and fee-for-service rates, medical services contracting practices, and quality of care. AHCCCS is currently authorized 1,537.5 FTEs and had a budget of approximately $3.67 billion in fiscal year 2002 to provide healthcare services to AHCCCS members. This amount includes AHCCCS expenditures of nearly $82 million and Arizona Department of Economic Security and Department of Health Services expenditures of approximately $85 million to administer AHCCCS programs.[1]

AHCCCS administers healthcare programs for approximately 790,000 low-income Arizonans.[2] Most of them receive acute and long-term care services through Medicaid, a joint federal/state healthcare program for low-income persons. AHCCCS also administers several other healthcare programs for low-income persons who are not eligible for Medicaid. (For a list of all 16 programs administered by AHCCCS see Appendix, pages a-i through a-iii.) AHCCCS primarily operates under a managed care system based on capitation rates, in which it contracts with health plans that in turn contract with healthcare providers to provide care for approximately 700,000 qualified persons. Additionally, AHCCCS has approximately 90,000 members who receive services on a fee-for-service basis, where AHCCCS directly pays providers for services. Fee-for-service program recipients are primarily served through the emergency services programs for non-qualified aliens and Indian Health Services for Native Americans.

Capitation rates: AHCCCS pays its health plans a fixed amount in advance each month for each member enrolled in the health plan regardless of the number or level of services provided.

Fee-for-service rates: AHCCCS directly compensates physicians and other healthcare providers for each service provided to its fee-for-service members.

1 Through intergovernmental agreements with AHCCCS, the Arizona Department of Economic Security receives funding to determine eligibility for most acute care Medicaid programs and the Department of Health Services receives funding for several functions, including inspection and licensure of Medicaid-certified nursing care facilities.

2 Enrollment information is as of July 1, 2002.

AHCCCS organization

AHCCCS is divided into nine offices and divisions. The performance audits conducted covered functions performed by all the divisions and offices with the exception of the Office of the Director and the Information Services Division.

The following five offices and divisions primarily serve AHCCCS members and oversee the health plans. Specifically,

- Division of Member Services (994 FTEs)—The Division of Member Services determines applicants' eligibility for three main program areas—the Arizona Long-Term Care System (ALTCS), Supplemental Security Income/Medical Assistance Only (SSI/MAO), and KidsCare. The division also performs quality control checks on the eligibility determinations that the Department of Economic Security (DES) performs. While DES performs most Medicaid acute care eligibility determinations, AHCCCS is responsible for ensuring that the Medicaid eligibility determinations are performed both accurately and in a timely manner. Further, the division operates a communications center, which provides information about programs to AHCCCS members and provides verification of AHCCCS members' enrollment to healthcare providers.

- Office of Managed Care (49.5 FTEs)—The Office of Managed Care has many responsibilities associated with overseeing AHCCCS' ten acute and eight ALTCS health plans. Specifically, the Office coordinates health plan procurements, working with other AHCCCS divisions involved with healthcare contracting to develop contract and request for proposal language, score and evaluate proposals, and negotiate contract terms with health plans. The Office monitors health plans' performance through regular review of their financial statements and annual onsite reviews that assess compliance with AHCCCS standards and contract requirements. It also works with an actuary to develop the capitation rates paid to health plans. Further, it maintains a large database of all services provided to AHCCCS members, which it validates and uses to develop appropriate capitation rates. Finally, the Office sets fee-for-service rates to pay for services provided to Native Americans enrolled with Indian Health Services or individuals served through AHCCCS' emergency services programs.

- Office of Medical Management (60 FTEs)—The Office of Medical Management is responsible for evaluating health plan practices for monitoring and improving the quality of services provided to AHCCCS members. The Office uses four primary mechanisms to monitor the quality of care. Its staff participate in the annual onsite reviews of health plans; monitor the care provided to members through the quality-of-care complaints it receives; review quality management plans developed by the health plans; and use 17 clinical performance indicators

to assess how well the healthcare system is delivering services to AHCCCS populations. The Office also tracks the utilization of services by AHCCCS members, preauthorizes high-cost services, such as transplants and treatment for severe head injuries, and manages contracted pharmaceutical services.

- Office of Legal Assistance (50 FTEs)—The Office of Legal Assistance receives and handles member and provider grievances. Grievances might include a health plan's decision to deny a medical service for a member or to reduce payment to a medical provider. The Office handles grievances by setting up hearings with the Office of Administrative Hearings and providing an informal adjudication process for grievances. It also oversees, reviews, and approves grievance procedures adopted by AHCCCS health plans; provides legal counsel for AHCCCS; and administers AHCCCS' human resources functions.

- Division of Business and Finance (158 FTEs)—The Division of Business and Finance handles a variety of administrative functions for AHCCCS including developing budgets, processing fee-for-service claims, administering all federal funds, handling payroll, and administering contracts. A contracts and purchasing unit within the division is responsible for maintaining some contract records for the acute and long-term care contracts, working with the Office of Managed Care to coordinate contract procurements, and serving as the main point of contact with health plans during the procurement process.

The remaining four offices and divisions provide policy direction and technical support for the entire agency. Specifically,

- Office of the Director (38 FTEs)—The Office of the Director coordinates AHCCCS' quality program and strategic plan, provides the overall policy direction for AHCCCS, and provides public information and community education. It also includes the Healthcare Group program (see Appendix on page a-ii).

- Office of Program Integrity (18 FTEs)—The Office of Program Integrity is responsible for the prevention, detection, and investigation of fraud and abuse by providers, health plans, and members in the AHCCCS program. The Office employs investigators to conduct preliminary investigations of suspected cases of provider and member fraud and abuse. The Office also conducts audits of AHCCCS programs and services in an effort to detect fraud and abuse and improve fraud control procedures.

- Office of Policy Analysis and Coordination (14 FTEs)—The Office of Policy Analysis and Coordination drafts and monitors legislation and rules and maintains the AHCCCS federal waiver and state plan. The waiver allows AHCCCS to operate a Medicaid managed care program and the state plan documents how AHCCCS complies with federal law. The waiver and state plan must be approved by the U.S. Department of Health and Human Services,

Centers for Medicare and Medicaid Services (CMS). The Office also assists in developing medical services requests for proposals to ensure all federal and state requirements are addressed. Further, it serves as AHCCCS' liaison to CMS.

- Information Services Division (152 FTEs)—The Information Services Division develops and maintains AHCCCS' automated information systems and provides technical support to AHCCCS' other divisions. It also produces reports used by the Office of Managed Care to help develop the capitation rates paid to health plans.

In addition to these offices and divisions, the Legislature has authorized four FTEs for the Advisory Council on Indian Health Care. This council has been established to develop a comprehensive healthcare delivery and financing system specific to each Arizona Indian tribe that uses Medicaid funds. The 23-member council includes 20 tribal members appointed by the Governor and one representative each from AHCCCS, the Arizona Department of Health Services, and the Arizona Department of Economic Security.

Scope and methodology

AHCCCS' performance was analyzed in accordance with the 12 statutory sunset factors. The following audits were completed:

- Division of Member Services (Report No. 02-05)
- AHCCCS rate-setting processes (Report No. 02-06)
- Medical services contracting (Report No. 02-07)
- Quality of care (Report No. 02-08)

Information obtained from AHCCCS officials, the Governor's Regulatory Review Council, the Department of Administration, the Office of the Secretary of State, and the Office of the Attorney General is also included.

SUNSET FACTORS

In accordance with A.R.S. §41-2954, the Legislature should consider the following 12 factors in determining whether the Arizona Health Care Cost Containment System (AHCCCS) should be continued or terminated. The evidence assembled under these 12 factors indicates the continued need for AHCCCS. However, the four performance audits identified opportunities for AHCCCS to improve operations in several ways.

1. The objective and purpose in establishing the agency.

In 1981, legislation was passed establishing AHCCCS as a division within the Department of Health Services to provide medical services to low-income Arizonans. By establishing AHCCCS, the Legislature sought to bring federal Medicaid dollars into the State to relieve the counties' burden of the growing cost of indigent healthcare. Statute required AHCCCS to establish contracts with providers for the provision of hospitalization and acute care medical coverage to members. In 1984, legislation created AHCCCS as an independent state agency. In 1987, the Legislature added long-term care services through the Arizona Long Term Care System (ALTCS) to AHCCCS' acute care services. AHCCCS currently defines its mission as follows:

> "Reaching across Arizona to provide comprehensive, quality health care for those in need."

In support of this mission, the eight offices and divisions within AHCCCS perform four central functions:

- Administering system to deliver medical services—AHCCCS primarily uses a managed care system with prepaid monthly capitation rates to deliver acute care and ALTCS services to approximately 700,000 members statewide.[1] Arizona was the first state to establish a statewide managed care Medicaid system. Additionally, AHCCCS has approximately 90,000 members who receive services on a fee-for-service basis, where AHCCCS directly pays providers for services.

1 Enrollment information is as of July 1, 2002.

- **Determining eligibility**—AHCCCS determines and oversees applicant eligibility for various healthcare programs for low-income Arizonans (see Appendix on pages a-i through a-iii for an overview of AHCCCS programs). Applicants must meet income requirements, and for the ALTCS program, must also meet medical eligibility requirements.

- **Overseeing health plans**—AHCCCS contracts with health plans to deliver services. AHCCCS requires that all health plans adhere to standards stated in their contracts and performs annual onsite reviews to ensure compliance in areas such as financial management, delivery systems, member services, and quality management.

- **Monitoring quality of care**—AHCCCS monitors the quality of care delivered to its members through annual onsite reviews of health plans, quality-of-care complaints it receives, review of quality management plans developed by the health plans, and 17 clinical performance indicators that track how well AHCCCS is delivering services to its members.

2. **The effectiveness with which the agency has met its objective and purpose and the efficiency with which it has operated.**

AHCCCS has effectively met its overall objective and purpose. AHCCCS has established an effective managed care system focused on reducing costs through competition, increasing healthcare choice for its members, and obtaining a quality healthcare delivery network. While other states are reporting that fewer health plans have been competing for managed care contracts, AHCCCS' acute care program has been more successful in attracting competition. Additionally, AHCCCS has been able to effectively manage member growth and has implemented seven new programs or eligibility groups within the past 5 years. Further, AHCCCS has used a sound procurement process for its medical services contracts and developed appropriate rate-setting processes.

However, AHCCCS can improve its effectiveness in ensuring the quality of care delivered through its program. Specifically, the AHCCCS Quality of Care report (Report No. 02-08) identifies several ways AHCCCS can enhance its quality-of-care monitoring. For example, AHCCCS can strengthen its annual onsite reviews by focusing them more on health plans' actual performance in addition to reviewing health plan policies and processes. Further, AHCCCS needs to take additional steps to ensure that the quality-of-care complaints it refers to health plans are appropriately resolved. Finally, AHCCCS needs to do more to ensure that quality-of-care concerns for its ALTCS developmentally disabled members served by the Arizona Department of Economic Security's Division of Developmental Disabilities are addressed.

AHCCCS has also operated efficiently. Despite over 52 percent growth in new members since state fiscal year 2000, AHCCCS reports its staffing levels have increased by approximately 20 percent.[1] Further, the AHCCCS Division of Member Services report (Report No. 02-05) identifies examples of actions AHCCCS has taken to improve its efficiency in the eligibility determination process and the services provided through its Communications Center. For example, AHCCCS has significantly reduced the number of ALTCS medical reassessments it performs because its data showed that the majority of the reassessments were not necessary. Additionally, AHCCCS has improved the ways its Communications Center shares enrollment and other information with AHCCCS members and healthcare providers. AHCCCS' improvement strategy has been based on developing various types of automated systems and encouraging members to call other, more appropriate sources, such as their health plan.

However, AHCCCS can further improve its efficiency by discontinuing its calculation of error rates for the KidsCare program. These error rates are neither meaningful nor federally required, and other methods are in place to ensure correct KidsCare eligibility determinations. (Report No. 02-05)

3. The extent to which the agency has operated within the public interest.

AHCCCS has operated in the public interest by administering a system that provides medical services to low-income Arizonans. Although the last state to implement a Medicaid program, Arizona developed the first statewide, acute care Medicaid managed care system. In a federal study, the General Accounting Office praised AHCCCS' successful efforts to reduce costs through contracting and competition.[2] AHCCCS has also established a reasonable system for monitoring health plans' financial solvency. Such a system is important because a health plan's financial insolvency could have profound effects on the AHCCCS system, potentially disrupting medical service provision to AHCCCS members and jeopardizing healthcare providers' participation in the system. Only one AHCCCS health plan has become insolvent. After this plan became insolvent, AHCCCS terminated its contract in April 1997.

Further, results from a recent survey of AHCCCS members were generally positive. In the 2000 Member Satisfaction Survey, 78 percent of AHCCCS survey respondents rated the healthcare they received as an "8," "9," or "10" on a scale

1 Much of the growth in members and FTEs can be attributed to Proposition 204, which was passed in November 2000 and expanded healthcare coverage in Arizona. In the first 8 months after the expansion became effective, enrollment in Medicaid increased nearly 22 percent (128,111 members). Further, of the 263 FTEs added since state fiscal year 2000, 195 FTEs are associated with Proposition 204.

2 United States General Accounting Office (GAO). Report to the Chairman, Committee on Commerce, House of Representatives. *Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs*. Washington, D.C.: October 1995.

from "0" (worst) to "10" (best). This compares to a national average of 70 percent of respondents rating the care they received as an "8," "9," or "10."

4. The extent to which rules adopted by the agency are consistent with legislative mandate.

According to the staff of the Governor's Regulatory Review Council (GRRC), AHCCCS has promulgated most, but not all, of the required rules. Based on its review of A.R.S. Title 36, Chapter 29, Article 1, GRRC staff report that AHCCCS has not developed rules related to disabled persons who qualify for services under the federal "Ticket to Work" program.[1] Specifically, these rules would address the eligibility process and premium collections. However, since the Ticket to Work program was considered for elimination due to budgetary concerns, AHCCCS postponed its work on these rules. This program has now been approved, and AHCCCS has told GRRC staff that these rules, which are exempt from GRRC review, will be filed in December 2002 with a planned effective date of January 1, 2003.

While AHCCCS has promulgated most of its required rules, it may need to make changes to its ALTCS rules. For example, AHCCCS has reduced the number of medical reassessments it performs, yet its rules still require it to perform medical reassessments for all ALTCS members. Administrative Rule R9-28-306(C) requires AHCCCS to perform a medical reassessment of members annually, with some exceptions. While rule also allows AHCCCS to identify additional population groups within ALTCS for which a reassessment period of greater than one year is appropriate, it does not permit AHCCCS to discontinue performing medical reassessments indefinitely for any members. If AHCCCS continues to not perform reassessments on some members, it needs to make appropriate rule changes. (Report No. 02-05)

5. The extent to which the agency has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

AHCCCS reports that it solicits and considers comments it receives during the rules promulgation process. AHCCCS receives comments from other state agencies, advocates, stakeholders, tribal representatives, and other organizations. The agency maintains a database of approximately 530 people and organizations that it uses to notify the public of proposed rules. Among those included in the database are advocates, its health plans, providers, state agencies, and legislators. In addition, draft rules are posted on the Internet and are published in the Arizona Administrative Register. Depending on the nature of the rule change, AHCCCS may also conduct informal meetings to better

1 The federal Ticket to Work Incentives Improvement Act of 1999 provides healthcare supports for working individuals with disabilities and access to employment training and placement services.

understand community concerns. AHCCCS last promulgated rules in July 2002 dealing with the payment of claims. Since 1999, AHCCCS has developed 27 rule packages covering issues such as eligibility and enrollment and breast and cervical cancer treatment.

Additionally, AHCCCS utilizes several other avenues to provide information to the public. For example, AHCCCS provides information about its services through:

- A Web site, which includes information on AHCCCS services and programs, eligibility requirements, downloadable application forms, various manuals and publications, and contact information for AHCCCS and its health plans.

- Several newsletters that target different groups and organizations that interact with AHCCCS. *AHCCCS Today* and *AHCCCS Hoy* (Spanish) are sent to community organizations and include program changes and detailed information tailored to the different organizations' needs. *Claims Clues* targets AHCCCS providers and provides information on claims (payment) issues and AHCCCS programs and services. Another newsletter, *The AHCCCS Road*, contains information regarding legislation, policy, and regulations that impact healthcare services for Native Americans.

- Community presentations and outreach by AHCCCS staff and contracted community-based organizations. AHCCCS staff gives presentations to the general public and special interest groups throughout the State about the overall program and changes to it.

The Advisory Council on Indian Health Care also conforms with open meeting law requirements by posting notices of public meetings at least 24 hours in advance at the required locations and having the required statement of where meeting notices will be posted on file with the Secretary of State.

6. The extent to which the agency has been able to investigate and resolve complaints that are within its jurisdiction.

AHCCCS has processes in place to handle grievances and quality-of-care complaints. Federal law requires that AHCCCS maintain a hearing system to address eligibility, service, and provider grievances. These grievances can involve decisions made by AHCCCS or its health plans regarding individuals' eligibility for AHCCCS, the services that will be provided to members, or provider reimbursement for services rendered. Members and/or providers are entitled to grieve or appeal these decisions to AHCCCS. AHCCCS' Office of Legal

Assistance receives and sets up formal hearings with the Office of Administrative Hearings for grievances to be heard. In addition, it provides a process to informally adjudicate grievances. AHCCCS also uses these processes to resolve provider grievances. In state fiscal year 2002, AHCCCS reported handling 7,459 grievances.

AHCCCS also receives hundreds of potential quality-of-care complaints annually. Complaints pertaining to the quality of care a member received, such as substandard nursing care or difficulty getting medications and services, can be sent either to the health plan or directly to AHCCCS for action. When AHCCCS receives quality-of-care complaints, it refers them to the appropriate health plan for investigation and resolution. In federal fiscal year 2001, AHCCCS reports directly receiving approximately 410 potential quality-of-care complaints from a variety of sources, including members, providers, and elected officials.

While it appears appropriate for AHCCCS to refer the quality-of-care complaints it receives to health plans for investigation and resolution, AHCCCS does not ensure that members' concerns or systemic problems identified are appropriately resolved. Auditors' review of 40 complaints found no assurance that AHCCCS or the health plans consistently document the appropriate resolution of member concerns. Further, even though AHCCCS has identified problems with the complaint-handling processes of 4 of 17 health plans, it has continued to refer complaints to these plans for investigation and resolution. (Report No. 02-08)

7. **The extent to which the Attorney General or any other applicable agency of state government has the authority to prosecute actions under the enabling legislation.**

The Attorney General and county attorneys have authority to prosecute actions under state law, while federal law enforcement authorities may pursue cases under federal law. The Attorney General's AHCCCS Fraud Control Unit investigates and prosecutes cases involving AHCCCS provider fraud, AHCCCS administration fraud, and member abuse, neglect, and financial exploitation by Medicaid providers. The unit reported 26 criminal indictments, including 15 for patient abuse, and 28 criminal convictions in state fiscal year 2001. Cases involving member eligibility fraud are investigated by AHCCCS and referred to and prosecuted primarily by the county attorneys. For state fiscal year 2002, AHCCCS reported that it conducted 571 member eligibility fraud investigations and referred 14 cases for prosecution.

Additionally, since AHCCCS receives federal funds, federal law enforcement authorities, including the Federal Bureau of Investigation, U.S. Department of Health and Human Services Office of the Inspector General, and the U.S.

Attorney, also have authority to prosecute violations under both federal criminal and civil statutes. Cases pursued by federal authorities, however, typically involve both Medicare and Medicaid funds. Between January 2001 and July 2002, there were no cases prosecuted by federal law enforcement authorities involving AHCCCS members or providers.

8. The extent to which the agency has addressed the deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate.

AHCCCS did not propose any legislation during the 2002 legislative session, but did propose several pieces of legislation that were enacted during the 2001 regular and special legislative sessions. Examples of 2001 legislation include:

- Laws 2001, Chapter 344, assists with the implementation of Proposition 204, which expands eligibility to AHCCCS services. Its provisions included repealing the counties' responsibility for performing eligibility determinations for medical care to the indigent sick and requiring AHCCCS to adopt rules for a streamlined eligibility determination process.

- Laws 2001, Chapter 360, made changes to the KidsCare program, including expanding covered benefits to include nonemergency transportation and unlimited eye care, and authorizing school districts to perform outreach and information activities.

AHCCCS has also proposed other important pieces of legislation in the past several years. For example:

- Laws 1999, Chapter 313, made changes to several AHCCCS programs, including accelerating the expansion of KidsCare eligibility from 150 percent federal poverty level (FPL) to 200 percent FPL, and requiring Healthcare Group health plans to cover medically necessary breast reconstruction following a mastectomy.

- Laws 1998, 4th S.S., Chapter 4, established KidsCare as Arizona's state children's health insurance program for children under 19 who are residents of Arizona, are not covered by private health insurance, and who do not qualify for Medicaid.

9. The extent to which changes are necessary in the laws of the agency to adequately comply with the factors in the Sunset Laws.

Audit work did not identify any needed changes to AHCCCS' statutes.

10. The extent to which the termination of the agency would significantly harm the public health, safety, or welfare.

Terminating AHCCCS will significantly harm the health and welfare of the public it serves since AHCCCS' responsibility is to provide comprehensive, quality healthcare for low-income Arizonans. Although counties previously provided medical services through their own indigent healthcare programs, AHCCCS was established to relieve the burden to the counties from the growing cost of indigent healthcare by bringing Medicaid dollars into the State. In fiscal year 2002, the State spent approximately $2.36 billion in federal matching funds. By terminating AHCCCS, Arizona would lose these funds, which will result in approximately 790,000 members served by AHCCCS losing their healthcare benefits unless another state agency assumed AHCCCS' role as Arizona's Medicaid agency.[1] Since AHCCCS provides medical services to about 15 percent of Arizona's population, terminating the agency could have ripple effects on Arizona's overall healthcare system. For example, since federal law requires hospital emergency rooms to treat all patients regardless of their ability to pay, these newly uninsured could further strain an already taxed emergency care system. Additionally, the Advisory Council on Indian Health Care, which was established to develop a comprehensive healthcare delivery and financing system for Arizona tribes, would also be terminated.

11. The extent to which the level of regulation exercised by the agency is appropriate and whether less or more stringent levels of regulation would be appropriate.

While AHCCCS does not exercise regulatory authority, statute does allow AHCCCS to accept authority from the Department of Health Services to enforce minimum certification standards for adult foster care providers. Audit work did not identify any areas where additional regulation would be appropriate.

12. The extent to which the agency has used private contractors in the performance of its duties and how effective use of private contracts could be accomplished.

AHCCCS uses contracting extensively. From its inception, the AHCCCS program was envisioned as a partnership that would use private and public managed care health plans to provide quality healthcare to members while containing costs. To achieve this, AHCCCS has contracted with ten acute care and eight ALTCS health plans that establish networks of physicians, hospitals, and long-term care services. Through these networks, the health plans provide medical services to members through the acute care and ALTCS programs. AHCCCS reports that 85 percent of its state and federal appropriation is paid to its health plans for healthcare delivery.

[1] The approximately 790,000 members reflect AHCCCS' population as of July 1, 2002. This figure does not include the Premium Sharing programs, Healthcare Group, and certain populations within the Medicare Cost Sharing programs. With these groups added, the total population would be approximately 817,400.

AHCCCS also contracts out other services. For example, AHCCCS contracts with a variety of consultants to provide management, actuary, and legal services. Further, in January 2001, AHCCCS began using a prescription benefit management company to administer the AHCCCS fee-for-service prescription benefit. This project received the Governor's Spirit of Excellence Award in 2002. In addition, AHCCCS contracts out other services, including custodial, mailroom and courier, building security, landscape and building repair/maintenance, and vehicle and equipment repair/maintenance.

Audit work did not identify other uses for private contracts by AHCCCS.

APPENDIX

AHCCCS medical coverage programs as of July 2002

Using information obtained from AHCCCS' Web site and staff, auditors summarized the various medical coverage programs provided through AHCCCS as of July 2002. With the exception of the Healthcare Group, applicants for these programs must meet income requirements. Further, to be eligible for the Arizona Long-Term Care System, applicants must also meet medical eligibility requirements. The programs are listed in descending order based on the number of members served as of July 2002. Enrollment information is provided in parentheses after the program name.

- *AHCCCS for Families with Children* (368,561 members) provides acute care services, such as doctor visits, outpatient health services, and hospitalization, to families with at least one child in the household under the age of 18 years (or 19 years, if a full-time student).

- The *Supplemental Security Income/Medical Assistance Only* program (93,651 members) provides acute care services to individuals who are aged (65 and over), blind, or disabled, but do not qualify for Supplemental Security Income.

- *SOBRA* (81,381 members) provides acute care medical coverage to pregnant women and children up to the age of 19 years. SOBRA stands for the federal Sixth Omnibus Budget Reconciliation Act, which included provisions creating this program.

- *AHCCCS Care* (77,481 members) provides acute care services to individuals or couples without children.

- *KidsCare* (49,027 members) is Arizona's state children's health insurance program. It provides acute care services to children under 19 who are residents of Arizona, but are not covered by private health insurance.

- *Transitional Medical Assistance* (46,536 members) provides up to 2 years of ongoing medical assistance for families who were previously eligible for AHCCCS for Families with Children but became ineligible due to an increase in earned income.

- *The Arizona Long-Term Care System (ALTCS)* (34,665 members) is for aged (65 and over), blind, or disabled individuals who need medical care, skilled or intermediate nursing care provided in institutions, and behavioral health services. ALTCS also provides support services for program participants living in their own homes or in assisted living facilities.

- The *Medicare Cost Sharing* programs (12,637 members) provide help with Medicare costs, such as premiums, for people who are aged (65 and over), blind, or disabled and who are eligible for Medicare Part A hospital insurance.

- *Healthcare Group* (approximately 12,499 members) is a prepaid medical coverage plan marketed to small, uninsured businesses with 1 to 50 employees (including sole proprietors) and employees of political subdivisions. Unlike most insurance carriers, which market only to groups with more than five employees, Healthcare Group markets to all eligible groups. Employers and/or employees pay 100 percent of the premiums. While these premiums do not cover high-cost services, such as transplants and treatment of traumatic brain injuries, the State shares the risk and costs of these services with its contracted health plans by partially reimbursing the health plans for the cost of these services.

- *1931 Related* (12,162 members) includes several eligibility categories. For example, one program provides medical assistance for adopted and foster children deemed eligible by the Department of Economic Security's Division for Children, Youth, and Families. The "1931" refers to the section of the Social Security Act that authorizes these programs.

- The *Family Planning Services* program (9,650 members) is limited to providing family planning services to women who have been enrolled in the SOBRA program. There are some exceptions and eligibility begins 6 weeks postpartum.

- The *Federal Emergency Services* program (9,360 members) provides limited medical services to individuals who would normally qualify for AHCCCS for Families with Children, SOBRA, or Supplemental Security Income/Medical Assistance Only; however, they do not meet U.S. citizenship or qualified immigrant requirements.

- The *Premium Sharing Program* (5,581 members) provides medical coverage for uninsured individuals who have lacked health insurance coverage for at least 1 month, unless the loss of health insurance was involuntary. Members pay a share of the premiums. Individuals who are eligible for Medicare, Medicaid, or

for medical services through the Veterans Administration are not eligible for this program. Two hundred spaces with higher income eligibility limits are reserved for persons with specific chronic illnesses.

- The *Medical Expense Deduction* program (3,836 members) provides acute care medical coverage for individuals who do not qualify for other AHCCCS programs because their income is too high. Eligibility for this program depends on certain circumstances in which their medical expenses reduce their monthly income to 40 percent of the federal poverty level. As of April 1, 2002, this is $296/month for an individual and $604/month for a family of four.

- The *State Emergency Services* program (376 members) provides limited medical services to individuals who would normally qualify for AHCCCS Care or the Medical Expense Deduction program; however, they do not meet U.S. citizenship or qualified immigrant requirements.

- The *Breast and Cervical Cancer Program* (11 members) provides acute care services to women screened and diagnosed as needing treatment for breast and/or cervical cancer by the Well Woman Healthcheck Program administered by the Arizona Department of Health Services. This program began January 1, 2002.

AGENCY RESPONSE

AHCCCS

Jane Dee Hull
Governor

Phyllis Biedess
Director

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Committed to Excellence in Health Care

September 18, 2002

Debra K. Davenport, CPA
Auditor General
Office of the Auditor General
2910 North 44th St, Ste 410
Phoenix, AZ 85018

RE: Sunset Factor Evaluation, Report dated September 11, 2002

Dear Ms. Davenport:

Thank you for the positive AHCCCS, Sunset Factor Evaluation. We appreciate the efforts of the audit team.

As detailed in the report the AHCCCS administrative appropriation for FY02 included nearly $82 million for AHCCCS and $85 million for the Arizona Department of Economic Security and Department of Health Services. However, we believe this administrative appropriation and all subsequent ones would benefit from greater oversight if placed in the respective agency budgets to align with the program funding.

In order to address a number of the issues raised by your staff, AHCCCS and the Arizona Department of Economic Security need to continue developing an even stronger partnership to ensure that concerns with care for ALTCS developmentally disabled members are addressed timely and comprehensively.

Page eight of the report identified a concern with regards to the ALTCS redetermination process and current authority in rule. We believe the current rule as promulgated provides the AHCCCS administration the flexibility to identify population groups within the ALTCS Program for which a reassessment period greater than one year is appropriate. However, once we finalize the changes to the reassessments, which will be based on more experience with the current pilot process, we will make the appropriate changes in the rule. To clarify the reason for AHCCCS' actions in altering its reassessment process, less than 1% of the 16,500 reassessments were determined to no longer require ALTCS services. More important, more than 99% of our ALTCS members were appropriately placed in this program.

I would like to thank the Auditor General and staff for their time in evaluating AHCCCS. We appreciate the professional approach of the audit team as well as their cooperative attitude with AHCCCS staff.

Sincerely,

Phyllis Biedess
Director

PBDR:gs

Performance Audit Division reports issued within the last 12 months

01-19 Arizona Department of Education—Early Childhood Block Grant
01-20 Department of Public Safety—Highway Patrol
01-21 Board of Nursing
01-22 Department of Public Safety—Criminal Investigations Division
01-23 Department of Building and Fire Safety
01-24 Arizona Veterans' Service Advisory Commission
01-25 Department of Corrections—Arizona Correctional Industries
01-26 Department of Corrections—Sunset Factors
01-27 Board of Regents
01-28 Department of Public Safety—Criminal Information Services Bureau, Access Integrity Unit, and Fingerprint Identification Bureau
01-29 Department of Public Safety—Sunset Factors
01-30 Family Builders Program
01-31 Perinatal Substance Abuse Pilot Program
01-32 Homeless Youth Intervention Program
01-33 Department of Health Services—Behavioral Health Services Reporting Requirements

02-01 Arizona Works
02-02 Arizona State Lottery Commission
02-03 Department of Economic Security—Kinship Foster Care and Kinship Care Pilot Program
02-04 State Parks Board—Heritage Fund
02-05 Arizona Health Care Cost Containment System—Member Services Division
02-06 Arizona Health Care Cost Containment System—Rate Setting Processes
02-07 Arizona Health Care Cost Containment System—Medical Services Contracting
02-08 Arizona Health Care Cost Containment System—Quality of Care

Future Performance Audit Division reports

Department of Economic Security—Child Protective Services, Removal/Appeal Process

Children's Behavioral Health